CONFIDENTIAL

State of California
Initial Treatment Plan
BC-VOC-0410.1 (Rev. 11/99)

Return Form To:
Victims of Crime Program
P.O. Box 3036
Sacramento, CA 95812-3036
Or Your Local Victim/Witness Center Verification Unit

State Board of Control
Victims of Crime Program

Claim #	**Date Form Sent**
Victim's Name	**Claimant's Name**
Patient's Name	**Incident Date**

PLEASE PRINT CLEARLY OR TYPE

INITIAL TREATMENT PLAN

THE VICTIMS OF CRIME PROGRAM HAS RECEIVED AN APPLICATION/SUPPLEMENTAL BILL FOR MENTAL HEALTH SERVICES. IN ORDER FOR THE PROGRAM TO VERIFY THE CLAIMED LOSS, PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADDRESS SPECIFIED ABOVE. PLEASE ANSWER QUESTIONS FULLY AND COMPLETE THE SIGNATURE PAGE AT THE END OF THE DOCUMENT. USE ADDITIONAL PAGES WHEN NECESSARY.

If this patient terminated treatment with you after 10 or fewer sessions, you must complete this form by answering questions 1-19 only. Submit this form with your closing bill.

All questions on this form must be completed to request reimbursement for 11-30 sessions. Reimbursement for further sessions, if they are required, must be requested on the Extended Treatment Plan form that will be sent to you prior to completion of 30 sessions.

1. Name of Patient	**2. Name of Victim**	**3. Patient's Relationship to Victim**
4. Name of Therapist	**5. License/Registration # and Expiration Date**	**6. Provider Organization Name**

7. Check Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)

- ❒ **LMFT**
- ❒ **LCSW**
- ❒ **Licensed Clinical Psychologist**
- ❒ **Licensed Psychiatrist**
- ❒ **Psychological Assistant Intern**
- ❒ **LMFT Intern**
- ❒ **ASW**
- ❒ **Registered Psychologist**
- ❒ **Resident in Psychiatry**
- ❒ **Other (Please specify):**

8. Name and Title of Supervising Therapist (If applicable)	**9. License #**	**10. Expiration Date**

11. Please provide the approximate date(s) of the crime(s) and describe the circumstances which qualify this patient for Victims of Crime assistance, insofar as you have been informed of them.

12. Please describe the concerns which caused this patient to seek a consultation with you. (Note: If there is a lapse of more than 6 months between the last date of crime or the last date of previous mental health service, please include an explanation for that lapse.)

13. To your knowledge has this patient received mental health service at any time prior to your consultation?

- ❒ **None known**
- ❒ **Outpatient services**
- ❒ **In-patient services**
- ❒ **Psychotropic medications**
- ❒ **Other mental health interventions (Please specify):**

14. Please evaluate this patient with respect to the DSM IV criteria. Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

15. Please describe the symptoms which support your Axis I diagnosis.

16. In the past 3 months, has this patient exhibited any of the following symptoms at a level that you consider clinically significant? Please check all that apply.

- ❒ Aggression
- ❒ Anger
- ❒ Anxiety
- ❒ Apathy
- ❒ Avoidance
- ❒ Behavior problems
- ❒ Compulsive behavior
- ❒ Crying
- ❒ Denial
- ❒ Depression
- ❒ Difficulty concentrating
- ❒ Disordered eating symptoms
- ❒ Dissociation
- ❒ Emotional numbing
- ❒ Fear
- ❒ Flashbacks
- ❒ Guilt
- ❒ Harm to others/threats to others
- ❒ Hyperactivity
- ❒ Hyperarousal
- ❒ Insomnia/sleep problems
- ❒ Irritability
- ❒ Memory problems
- ❒ Nightmares
- ❒ Obsessive behavior
- ❒ Panic
- ❒ Phobias
- ❒ Self-blame
- ❒ Self-destructive relationships
- ❒ Self harm behaviors/impulses
- ❒ Sexual acting out
- ❒ Sexual dysfunction
- ❒ Somatic complaints
- ❒ Substance abuse withdrawal
- ❒ Other: _____

_____

17. If this patient is 6 years of age or older, please evaluate the patient on the Social and Occupational Functioning Assessment Scale (SOFAS) that is discussed in the DSM IV: _____.

❒ **Patient is under 6 years of age.**

18. Please evaluate the patient on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the DSM IV: _____. (Note: Rate the relational unit in which this patient resided at the time of this report.)

NOTE: IF YOUR TREATMENT OF THIS PATIENT TERMINATED AFTER 10 SESSIONS OR LESS, ANSWER QUESTION 19. IF TREATMENT IS CONTINUING, PROCEED TO NO. 20.

19. Please describe your patient's discharge status.

Last date of service: _____

❒ **Unplanned termination**

Reason:

❒ **Chief complaint(s) mainly resolved**

❒ **Treatment deferred until a later time**

Reason:

❒ **Referral to another mental health provider**

❒ **Other (Please specify):**

IF YOUR TREATMENT OF THIS PATIENT TERMINATED AFTER TEN OR FEWER SESSIONS, PLEASE SIGN THIS FORM AND RETURN IT WITH YOUR CLOSING BILL.

20. Are you requesting reimbursement for <u>more</u> than 10 sessions?

❒ **Yes (IF YES, PLEASE CONTINUE WITH QUESTIONS 21-26)**

❒ **No**

21. TREATMENT PLAN

Please state your goals for the first 6 months of treatment and describe how you hope to accomplish these goals. Whenever possible, state your goals in behavioral or measurable terms. Do not include goals that would be generic to any treatment plan (e.g., build rapport, increase self-esteem, etc.). Describe any collaborative and/or adjunctive services (e.g., medical consultation) you deem necessary to reach these goals.

Goals	Methods
1.	
2.	
3.	

22. Please identify any of the following factors which may impede your treatment during the next 6 months.

	No/not applicable	Yes
Mental status	❒	❒
Personal history	❒	❒
Support system	❒	❒
Justice system status	❒	❒
Family integrity	❒	❒
Economic/employment status	❒	❒
Other: _____	❒	❒

If you answered yes to any factors above, please explain.

23. Based on the information presently available, what is your rating of this patient's prognosis for resolution of the concerns for which you were consulted?

❒ **Excellent**
❒ **Good**
❒ **Fair**
❒ **Poor**

24. What is your expected date of termination with this patient?

Date: _____

BEFORE COMPLETING THIS SECTION, PLEASE REFER TO THE "RESTITUTION HEARING" INFORMATION ON THE LAST PAGE OF THIS FORM.

25. In your opinion, what percentage of your treatment is necessary to address the effects of the qualifying crime? (Note: It is understood that in the initial phase of treatment (i.e., first 30 sessions), your treatment may be focused on conditions which were caused directly by the qualifying as well as on pre-existing conditions which were exacerbated by the crime.)

❒ **Less than and including 50%**
❒ **More than 50%**
❒ **100%**

26. If your treatment focus includes conditions which were not originally caused by the crime but which all are exacerbated by the crime such that they now require attention, please describe those conditions and the way(s) in which they are exacerbated. (Note: After the initial phase of treatment, continuing treatment of pre-existing conditions can affect your reimbursement, if it is determined that such treatment is not necessary for the patient's recovery from the qualifying crime.)

Pursuant to Government Code section 13965(a)(1) a private nonprofit agency that treats victims referred by a public agency at reduced cost may be reimbursed at their normal and customary fee not to exceed the maximum rates set by the Board.

As required by law, the information requested by the State Board of Control (Board), which administers the VOC Program, must be returned to the Board within 10 business days. The Board verifies that: (1) this is a verification form requesting information that must be provided at no cost to the patient, the Board, or local Victim/Witness Assistance Centers, and (2) that we have a signed authorization on file for the release of the information requested. (Government Code Section 13962(b))

RESTITUTION HEARING

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for the victim. Although this will occur infrequently, the treating therapist must be prepared to testify in a restitution hearing that all mental health counseling expenses paid by the Board were necessary as a direct result of the crime.

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete, and; (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary as a direct result of the crime described in (11) above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

Treating Therapist:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

If Registered Intern:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____